UNITED STATES MARINE CORPS
MARINE CORPS BASE
PSC BOX 20004
CAMP LEJEUNE, NORTH CAROLINA 28542-0004

BO 1752.3
HSVC
6 AUG 1996

BASE ORDER 1752.3

From: Commanding General
To: Distribution List

Subj: TRANSITIONAL COMPENSATION FOR ABUSED FAMILY MEMBERS

Ref: (a) ALMAR 145/96
(b) 38 U. S. C. 1311

Encl: (1) Application For Transitional Compensation (Sample Form)

1. Purpose. To set forth policies and amplifying instructions regarding references and to provide guidance for the Transitional Compensation for Abused Family Members (TCAFM) established per reference (a).

2. Background. TCAFM is a congressionally authorized program that provides 12 to 36 months of support payments to family members of service members who are being separated from active duty because of domestic violence. These support payments are designed to assist family member(s) in establishing a life apart from the abusive service member. Monthly payments are based on dependency and indemnity rates as described in reference (b). Commissary and exchange privileges are allowed for the duration of the payments. Health care benefits, medical or dental, are available for one year, upon request, for an injury or illness resulting from the abuse.

3. Eligibility

a. TCAFM applies in cases of service members who have been on active duty for more than 30 days and who, on or after 30 November 1993, have been:

(1) Convicted of a family member abuse offense resulting in a punitive separation from active duty pursuant to a court-martial sentence.

(2) Administratively separated from active duty if the basis for separation includes a family member abuse offense.

b. Payments are made to abused family members to include spouse and dependent child(ren).

(2) For enlisted service members, the "obligated active duty service" is the time remaining on their term of enlistment.

(3) For officers, the "obligated active duty service" is indefinite unless the officer has a date of separation established, in which case it is the time remaining until the date of separation.

c. Monthly payments are modified annually and are established per reference (b).

6. Commissary and Exchange Benefits

a. Recipients are also entitled to use commissary and exchange stores while receiving their payment.

b. Recipients requesting commissary benefits should request DD Form 2, ID Card(s), in Section III of the enclosure.

7. Health Care Benefits

a. Abused family members of discharged or dismissed former service members, pursuant to a sentence at court-martial, may request, from the Secretary of the Navy, medical or dental care for an injury or illness resulting from the abuse.

b. The Secretary of the Navy may, upon request of the abused family member, furnish medical or dental care to the family member at a Military Treatment Facility (MTF) nearest to where the family is living.

c. Medical or dental care furnished to a family member in a MTF, shall terminate one year after the date on which the service member is discharged or administratively separated from active duty.

d. The request for medical or dental care should be made in Section III of the enclosure. The request for medical or dental care should be made to the nearest MTF to where the family member is living. The MTF will endorse the request and forward it to the Bureau of Medicine and Surgery for approval.

8. Annual Certification

a. The spouse or a court appointed guardian will certify annually to the Defense Finance Service - Denver (DFAS-Denver)

(6) Providing a copy of the completed DD Form 1698 to the Family Counseling Center/Family Advocacy Program Managaer.

10. Reserve Applicability. This Order is applicable to the Marine Corps Reserve.

11. Concurrence. This Order has been coordinated with and concurred in by the Commander, U.S. Marine Corps Forces, Atlantic; and Commanding Generals, 2d Marine Division and 2d Force Service Support Group.

P. G. Howard

P. G. HOWARD

DISTRIBUTION: A

APPLICATION FOR TRANSITIONAL COMPENSATION

All information except item 12 is to be entered by Service representative from Service records.

SECTION I - PAYEE INFORMATION
(If more than one eligible dependent, use the Remarks section on back to enter applicable information for each payee.)

1. PAYEE NAME *(Last, First, Middle Initial)*	2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH *(YYYYMMDD)*	4. SEX *(X one)* ☐ MALE ☐ FEMALE

5. ADDRESS

a. STREET *(Include apartment number)*	b. CITY	c. STATE	d. ZIP CODE

6. RELATIONSHIP TO MEMBER *(X one)*
☐ SPOUSE ☐ FORMER SPOUSE ☐ CHILD ☐ ADOPTED CHILD ☐ STEPCHILD

7. CUSTODY *(If payee is spouse or former spouse, enter names of dependent children from Item 23 who are in payee's custody) (If all, enter "ALL")*

8. INCAPACITATION

YES	NO	*(X Yes or No for each item)*
☐	☐	a. IS PAYEE INCAPACITATED? *(If Yes, complete Items 8.b. and c., and Item 9.)*
☐	☐	b. IS PAYEE INCAPABLE OF HANDLING FINANCIAL AFFAIRS? *(If Yes, complete Item 10.)*
☐	☐	c. IS PAYEE INCAPABLE OF SELF SUPPORT?

9. IS INCAPACITY: *(X one) (If applicable)* ☐ PERMANENT ☐ TEMPORARY

10. LEGAL REPRESENTATIVE *(Complete only if legal representative is not the payee.)*

a. NAME *(Last, First, Middle Initial)*	b. STREET ADDRESS *(Include apartment/suite no.)*	c. CITY	d. STATE	e. ZIP CODE

11. IF PAYEE IS A CHILD: *(X Yes or No for each item.) (NOTE: Age of majority for a child is 18 in all states except the following: Alabama, Nebraska and Wyoming: age of majority is 19; Mississippi, West Virginia and Puerto Rico: age of majority is 21.)*

YES	NO	
☐	☐	a. WAS INCAPACITY INCURRED BEFORE AGE 18?
☐	☐	b. IF INCAPACITY WAS INCURRED BETWEEN AGES 18 AND 23, WAS THE CHILD A FULL-TIME STUDENT?
☐	☐	c. IS CHILD UNDER THE AGE OF MAJORITY? *(See NOTE. If Yes, complete Item 10.)*
☐	☐	d. WAS CHILD DEPENDENT ON FORMER MEMBER FOR OVER ONE-HALF OF SUPPORT?

12. PAYEE CERTIFICATION *(Payee must sign and date to certify that the statements below are correct. Lines (2)-(4) apply only to spouse or former spouse.)*
(1) I am not cohabiting with the former member. If status changes, I will notify DFAS within 30 days.
(2) I have not remarried. If status changes, I will notify DFAS within 30 days.
(3) I have custody of the dependent children listed in Item 7.
(4) I was married to the member in Item 14 at the time of the dependent abuse offense resulting in his conviction/administrative separation.
(5) I claim payment of transitional compensation under Section 1059, Title 10, U.S.C.
(6) I understand that I may not receive payments under both Section 1059 and Section 1408(h) of Title 10, U.S.C., and that, if eligible for both, I must elect which to receive. I elect payment of transitional compensation under Section 1059.

a. SIGNATURE *(Applicant acknowledges that acceptance of payments if the offender rejoins household is punishable under the law.)*	b. DATE SIGNED *(YYYYMMDD)*

SECTION II - MEMBER IDENTIFICATION

13. BRANCH OF SERVICE *(X one)* ☐ AIR FORCE ☐ MARINE CORPS ☐ ARMY ☐ NAVY	14. MEMBER NAME *(Last, First, Middle Initial)*	15. PAY GRADE *(Prior to conviction or separation)*

16. SOCIAL SECURITY NUMBER	17. DATE OF BIRTH *(YYYYMMDD)*	18. SEX *(X one)* ☐ MALE ☐ FEMALE

19. OBLIGATED SERVICE DATES *(YYYYMMDD)*

a. ACTIVE DUTY SERVICE ENTRY DATE	b. EXPIRATION OF ACTIVE OBLIGATED SERVICE *(Enlisted only)*	c. ESTABLISHED DATE OF SEPARATION AT TIME OF CONVICTION/ADMINISTRATIVE SEPARATION *(Officer only) (If none, so state)*

20. DATE OF APPROVAL OF THE COURT-MARTIAL SENTENCE/ ADMINISTRATIVE SEPARATION *(YYYYMMDD) (If court-martial, verify date with approving official. If administrative separation, use date of initiation of separation.)*

21. PAYMENT DATES *(YYYYMMDD) (Start date is date in Item 20. Length of payment is 36 months except as follows: Subtract date in Item 19.b. or 19.c. from the date in Item 20. If less than 36 months, length of payment is that period or 12 months, whichever is greater.)*

a. START	b. STOP

22. APPROVING OFFICIAL CERTIFICATION.
I certify that the offense resulting in court-martial conviction or involved in administrative separation is a dependent-abuse offense in accordance with DoD regulations. If married, the spouse was not a participant in the abuse offense.

a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*	c. TITLE	d. TELEPHONE *(Include area code)*

e. STREET ADDRESS *(Include apartment or suite number)*	f. CITY	g. STATE	h. ZIP CODE

DD FORM 2698, JAN 95

Enclosure (1)